was 93.3% at 19 months and 81.6% estimated at five years. Disease-free survival at mean follow-up was 89.7% and 74.4% 5 years. Rectal, urinary and vaginal late toxicity was moderate (CTC grade 2: 5.5%, 5.5% and 17.5% respectively). OS was significantly worse in patients with para-aortic disease compared with those without disease ($p < 0.000$) and in patients with prolonged (>8 weeks) radiation treatment ($p = 0.022$). 25 patients complete QLQ C30, QLQ CX24 and IFSF as measures of quality of life and sexual function with mean scores of 3.45/4 and 3.07/4 although IFSF mean score was 1.84/5.
Conclusions. Laparoscopic extraperitoneal aortic lymphadenectomy is a feasible procedure, which identify patients with para-aortic disease tailoring their treatment. The addition of para-aortic external radiation therapy seems to be well tolerated by the patients, with apparently no influence in quality of life.

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Conformed radiotherapy and chemotherapy with cisplatin/tegafur in cervix cancer

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Introduction. The uterine cervical carcinomas remain a health problem with poor survival rates and low rates of local and distant control. The use of 3D conformal radiotherapy (RTC3D) associated with concomitant chemotherapy (CT) utilizes a same therapeutic approach all the advantages of a multimodal treatment.
Objective. To perform a descriptive analysis end, a phase II study with QT induction RTC3D/QT and BRT/surgery effort.
Material and methods. Between February 1999 and April 2009 a total of 139 patients diagnosed with uterine cervical carcinoma were included. The mean age was 58 years (range 29–78). Stage distribution was: IB2 (5.75%), IIA (5.03%), IIB (40.3%), IIIA (2.9%), IIIB (31.6%), IV (7.91%) and no visceral IVB (6.47%). -Scheme of chemotherapy: a) A CT cycle induction Cisplatin 75 mg/m^2 and 750 mg/m^2 Tegafur. Concomitant CT: Cisplatin 25 mg/m^2 weekly and Tegafur 450 mg/m^2. - Scheme of Radiotherapy: Virtual simulation and 3-D planning. The total dose was 45–50.4 Gy.
Results. A total of 139 patients were performed until December 2012. With a median follow-up of 110 months (range 46–168 months) are still Alive (49.6%), Exitus (50.4%). Overall survival: by stages: IB2 (62.5%), IIA (85.7%), IIB (67.8%), IIIA (75%), IIIB (27.2%), IV A (36%), IV B (11.1%). Responses: CR 96 (69.1%), PR 31 (22.3%), ED1 patient (0.7%), PD 1 patient (0.7%), NA (7.2%). Profile of Recurrence: local (38), regional (37), remote (22), para-aortic note 9. Severe acute toxicity: hematologic 7.9%, gastrointestinal 5.7%, gynecological 2.9%, vascular 4.3%, other 2.9%. Severe chronic toxicity: retroperitoneal fibrosis 4.3%, gastrointestinal 2.9%, urological 1.4%, other 2.4%. Exitus: 4 patients: In patients surviving longer submitted 9 secondary neoplasms.
Conclusions. The survival for stages IB2 to IIIA is high of 62.5 to 85.7%. In IIIB to IVA is around 36% and 11.1% and the of percetntage loco – regional recurrence is high. Toxicity is manageable.

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Treatment outcomes of cervical cancer in a single institution

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Purpose. To analyze retrospectively the outcome of patients with cervical cancer treated with external beam radiotherapy (EBR) and high-dose-rate (HDR) brachytherapy.
Methods and materials. From November 2002 to November 2012, 89 patients with FIGO Stages IB to IVB were treated. The mean patient age was 53 years. Most frequently used EBR dose to the whole pelvis (with or without paraortic nodes included) was 45 Gy in 25 fractions. Parametrial or bulky lymph node (LN) boost was performed in 11.2% of patients. Brachytherapy with HDR was performed during EBR or following its completion with five weekly fractions of 5.5–6 Gy to point A. Within the EBR, 79 of the 89 patients (88%) received concomitant chemotherapy (weekly cisplatin: 52 patients or taxol: 27 patients). Patient age, tumor stage, LN metastases, para-aortic LN sampling and histology were variables analyzed for survival and local control; whereas, doses at organ risk were variables for analyzing late toxicity. Initially plain X-ray film simulation was the standard of care, but further in time, CT planning was performed. Doses at the rectum and bladder ICRU reference points were calculated for the first, and D2cc bladder, rectum and sigmoid were calculated for the second.
Results. Median follow-up time was 33 months. Three patients had stage I disease (3.3%); 44 stage II disease (49.5%); 32 stage III disease (36%) and 10 stage IV (11.2%). Five patients (6%) suffered local failure, 5 pelvic nodal failure (6%) and 21 (25%) distant metastases. Overall survival, disease-free survival, and loco-regional control at 5 years was 68.8%, 59.2%, and 81.9% respectively.

The actuarial late complication rate grade 3 was 1.1% for the bladder and 3.4% for the bowel and rectum. One patient suffered a GI grade 4 complication. Vagina shortening and obliteration occurred in 18.8%.
Conclusions. This series suggests that 45 Gy to the whole pelvis combined with five fractions of 5.5–6 Gy to point A with HDR brachytherapy in conjunction with concomitant chemotherapy is an effective and safe fractionation schedule in the treatment of stages IB to IVB of cervix cancer.

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Undifferentiated uterine sarcoma: A rare, not well known and aggressive disease

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Purpose. Undifferentiated Uterine Sarcoma (UUS) is a rare, not well known and aggressive disease. We retrospectively analysed the outcome of 13 patients diagnosed and treated at our centre.
Material and methods. From 1979 to 2010 the records and pathology of 13 patients diagnosed and treated for UUS were retrospectively analysed. Three patients had metastasis at diagnosis; 10 out 13 patients underwent surgery with a curative aim followed by radiation therapy (RT) in 8 patients (external beam radiotherapy and/or brachytherapy). Chemotherapy (ChT) was administered as an adjuvant treatment in 3 patients. The Kaplan–Meier actuarial method was used to analyse the overall survival (OS) and a descriptive analysis was used to know the frequencies.
Results. Median follow-up of the entire series was 16 months (2–276 months, mean 50,08). The mean age of the group was 66 years. FIGO 2009 stage: 3 IA, 5 IB, 2 IIB and 3 IVB. Patients with stage I developed 2 local relapses (in the only 2 no irradiated patients) and 3 distant metastasis; 50% of this group were long survivors. All patients in stage II developed distant metastasis. Distant metastasis was observed in 61.5% of the entire series. A half of patients treated with adjuvant RT were alive at the moment of the analysis, and no evidence of local relapse was viewed. The 3 patients that received adjuvant ChT died because progression of the disease (median survival 12 months). The median OS was 16 months (mean 77,8); for stage I was 17 months, being 9 months in the remaining patients (mean 126 vs14).
Conclusions. Poor outcome of UUS was associated with a high incidence of distant metastasis. Stage was the strongest predictor of bad outcome. Adjuvant RT seems to benefit these patients with 50% of long survivors. New treatment strategies should be considered in patients in whom distant metastasis are not found at diagnosis.

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USE of anaesthesia during gynaecologic brachytherapy procedures

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Introduction. Intracavitary brachytherapy, an essential part of any definitive treatment of locally advanced cervical cancer, is associated to aches and pain of varying intensity. For the proper insertion of devices as applicators, it is essential to immobilize the patient, the tumour and the surrounding organs. The presence of anaesthesiologists in Brachytherapy Units is strictly necessary.
Objectives. Evaluate the anaesthetic procedure in gynaecologic intracavitary brachytherapy in cervical cancer as standard practice.
Material and methods. 33 patients with locally advanced cervical cancer underwent to high dose rate Ir192 (HDR) gynaecologic intracavitary brachytherapy between 2010/2011. Median age was 55.81 (34–82) and 132 fractions. Patients were examined in the preanaesthesia consultation and signed the informed consent. The majority were classified based on the American Society of Anestesiologist (ASA) III (63,64%). Anaesthetic technique chosen was total intravenous anaesthesia (TIVA), induction and maintenance with propofol and remifentanil/fentanyl to maintain hemodynamic stability and the adequate degree of immobilization. Spontaneous ventilation with face masks or laryngeal mask (LM) or mechanical ventilation with LM or orotracheal intubation was used. 11% required the use of muscular relaxants. Patients were transferred to the simulation room, and then moved to the isolation room for treatment.
Results. At the end of the procedure, patients were lucid, supportive and without pain. No patient experienced nausea or vomiting nor required additional analgesia in the surgical room. They did not present any acute nor late complications related to anaesthesia. TIVA is well tolerated and provides good anaesthetic quality.
Conclusions. TIVA based on propofol and remifentanilo has a safety profile, fast metabolism and elimination. It is adequate technique for short procedure such as intracavitary gynaecologic brachytherapy on an outpatient basis and no complications were observed. Standard criteria for medical discharge are met at an earlier stage, significantly shortening the patient's stay at the hospital and minimize costs.

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